LETTERS TO THE EDITOR

Preference is given to letters commenting on contributions published recently in the *JRSM*.
They should not exceed 300 words and should be typed double spaced

Palliative medicine: is it really specialist territory?

The discussion about the future of palliative medicine as a specialty was timely and thought-provoking (November 1998 *JRSM*, pp. 568–572). As a former general practitioner who is now a consultant in palliative medicine, I have had experience on both sides of the fence. Whilst the article suggests that the philosophy of palliative care could be adequately practised by primary health care teams, thus making specialist palliative care redundant, my experience suggests otherwise. In order for this to happen, I feel the following issues would have to be addressed.

The medical model still prevalent in most hospitals and some general practices is inadequate compared with the holistic approach which specialist palliative care has championed. Effective multidisciplinary teamworking demands time which is in short supply in general practices and hospitals alike. Although training in palliative care at undergraduate and postgraduate level is improving, many GPs and hospital doctors still feel ill-equipped or unwilling to practise it. Palliative care was one of my special interests in general practice but it was not until I changed track that I realized my limitations. GPs and others cannot be expected to keep up with the changes occurring in palliative medicine and all other specialties. Leaving specialist nurses to plug the gap as the article suggests is fine when they are well-received but, unfortunately, not all doctors are willing to work in a truly multi-disciplinary way.

One of the obstacles to persuading sceptics about the value of specialist palliative care has been the difficulty in measuring aspects of quality of life in different settings. Whilst debate about the best way to do this continues, there is the danger of falling into the trap of believing that, because it is not measurable quantitatively, it cannot be credible. From the point of view of the patient and family, it is the less tangible factors such as feeling safe and knowing there is access in an emergency to someone well-versed in their individual physical and psychological state which make all the difference. Continuity can be difficult to achieve in primary care. Whilst palliative care problems could theoretically be cared for totally in the community, reduction in resources, especially the lack of twenty-four-hour nursing help, has made this extremely difficult, especially for elderly lay-carers. Specialist resources act as a back-up for these situations which demand extra help.

I will be delighted for patients if the utopia that Simon Fordham and colleagues predict is forthcoming. Meanwhile I think my job is reasonably safe.

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As a general practitioner with a special interest in palliative medicine, I found the article by Simon Fordham and colleagues unbalanced. It would have been helpful if they had attempted to summarize the achievements of the lead specialty. Briefly, in my opinion these are as follows:

1 Improved symptom control
2 General acceptance of the patient's 'right to know'
3 The effectiveness of teamwork in maintaining wellbeing in patients with terminal illness
4 Improvement of quality of life in patients who have been given a terminal diagnosis
5 Effective advocacy for this group of patients to obtain extra resources for them.

As a full-time GP, in recent years I have seen great improvements in the quality of life for patients with terminal illness. Much of this improvement in my opinion has come about through the active involvement of specialists in palliative medicine.

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Dr Fordham and colleagues' intriguing article contains some factual errors and hence fallacious conclusions. The future of MRCGP as an entry qualification to palliative medicine is not under threat. It is recognized by the Joint Committee on Higher Medical Training as one of the four postgraduate qualifications for entry to higher specialist training in palliative medicine. Currently, 215 Association for Palliative Medicine members (32%) hold MRCGP. Some took a drop in income to change career in later life, fearing burn-out or frustrated that current demands on modern general practice militate against holistic care of the seriously ill.

The authors notably omitted to mention the Calman–Hine report[1]. This policy document states 'Primary care is seen as the focus of care', recognizes that 'much palliative and terminal care is provided in the community by primary care teams' and expects specialist palliative care to work with primary care teams. This is not a model of specialists in palliative care taking over all those dying from cancer. Nor has it been suggested that palliative care advice to those with non-cancer diseases implies a take-over of general medicine and general practice[2].

The Calman–Hine report also states that 'palliative care should not be associated exclusively with terminal care. Many patients need it early in their disease, sometimes from the time of diagnosis'[1]. Fordham *et al.*'s assertion that palliative care referral signals imminent death and rejection is not borne out by hospice data on duration of care.

Specialist palliative care has indeed extracted proven best practice from general practice, nursing, pharmacology and other disciplines; a hierarchy of evidence is being sought for current recommended practice. As so many in palliative